STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8636 | www.rn.ca.gov

PSYCHOTROPIC (MOOD-ALTERING) DRUGS

QUARTERLY REPORTING PERIOD

☐ January 1 – March 31, _____ Year
☐ April 1 – June 30, _____ Year
☐ July 1 – September 30, _____ Year
☐ October 1 – December 31, _____ Year

Name of Probationary Nurse: _____ License #: _____

TO THE EXAMINER: The probationary nurse is serving a probation term with this Board and has chosen you, as his/her single physician, nurse practitioner or physician assistant, to coordinate and monitor any prescriptions for dangerous drugs, controlled substances or mood-altering drugs as required by a condition of probation. By completing this form you assure the Board that you: (1) you are aware of the probationer's history of substance abuse, (2) you will coordinate and monitor any prescriptions for dangerous drugs, controlled substances or mood-altering drugs, and (3) you will report to the Board on a quarterly basis the probationer's compliance with this condition. If any substances considered addictive have been prescribed, the report shall identify a program for the time limited use of any such substances. **Note: You must have at least 3 years of experience in treating health professionals with substance use disorder(s) as stated in the Board's Decision, Stipulated Settlement, Accusation and/or Statement of Issues. You must also have an active, unrestricted license, and be pre-approved by the Board.**

Before completing this form it is recommended that you obtain a CURES report for this nurse.
Please obtain a complete copy of the Board's Decision or Stipulated Settlement including the Accusation or Statement of Issues from the probationary nurse. Have the probationer sign a release form if necessary.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.
With regard to each Psychotropic medications which you are aware have been prescribed to the above listed nurse, please identify the following information:

1. MEDICATION NAME
2. DESCRIPTION/TYPE (e.g. opiate, benzo, anti-depressant)
3. REASON PRESCRIBED
4. PRESCRIBED BY
5. PRESCRIBED FROM/TO
6. DOSAGE
7. PROGNOSIS
8. EFFECT ON RECOVERY PLAN
9. IDENTIFY THE PLAN FOR WEANING OFF THIS MEDICATION

Examiner's Name: Specialty, if any:	License #
Address:	Phone ( )
Signature:	Date:

RETURN THIS FORM AND REPORT, TO:

Board of Registered Nursing-Probation Unit
Attn: Probation Monitor
PO Box 944210
Sacramento, CA 94244-2100